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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DAVID PAUL ALEXANDER** **551 Ventura Avenue** **San Mateo, CA 94403** **RN License No. 683001** Respondent.	Case No. 2011-689 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about July 12, 2006, the Board of Registered Nursing (Board) issued Registered Nurse License Number 683001 to David Paul Alexander (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges alleged in this Accusation and will expire on November 30, 2011, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in relevant part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in relevant part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 118, subdivision (b), of the Code provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued, or reinstated.

STATUTORY PROVISIONS

7. Section 2761 of the Code states, in relevant part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

. . .

"(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it."

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8. Section 2762 of the Code states, in relevant part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

. . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

9. Section 4022 of the Code states:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

"(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

DRUGS

10. Hydromorphone (Dilaudid) is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(k), and a dangerous drug as designated by Business and Professions Code section 4022.

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11. Morphine is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(M), and a dangerous drug as designated by Business and Professions Code section 4022.

COST RECOVERY

12. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FIRST CAUSE FOR DISCIPLINE
(Unprofessional Conduct)
((Bus. & Prof. Code §§ 2761(a) and 2762(e))

13. Respondent has subjected his Registered Nurse License to discipline for unprofessional conduct under Code section 2761, subdivision (a) and 2762, subdivision (e), in that he made false and grossly incorrect and inconsistent entries in hospital and patient records pertaining to controlled substances while working as a nurse in San Mateo, California. The circumstances are as follows:

14. On or about April 1, 2009 through June 15, 2009, Respondent, while working as a nurse in the Emergency Department of Mills Peninsula Health Services (MPHS), consistently failed to properly document the administration of medications. MPHS management officials reviewed Respondent's Pyxis machine[1] activity report from April 1, 2009 through June 10, 2009, and also reviewed 35 patient charts. The review showed a pattern of missing doses of narcotics, including Hydromorphone. The review also showed that Respondent was inconsistent in his wasting of doses. Further, the review indicated that Respondent removed medications for patients from the Pyxis machine which were neither ordered by a physician nor charted as administered to the patient. Narcotic discrepancies discovered by this review and attributable to Respondent are explained below:

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[1] A Pyxis machine is an automated dispensing system for medications kept in nursing units.

Patient 1

15. On April 1, 2009, at 12:24 p.m., 2:13 p.m., and 2:40 p.m., Respondent removed a 2 mg syringe of Hydromorphone from the Pyxis machine without a physician's order. There was no documentation that the medications were administered or wasted.

Patient 2

16. On April 2, 2009, at 10:19 a.m., Respondent removed two Hydromorphone 2 mg syringes from the Pyxis machine pursuant to a physician's order. However, there was no documentation that the medication was administered or wasted.

Patient 3

17. On April 6, 2009, at 12:07 p.m., Respondent removed one Hydromorphone 2 mg syringe from the Pyxis machine. Respondent documented the administration of only 1 mg. The remaining 1 mg was not documented as administered or wasted.

Patient 4

18. On April 3, 2009, at 1:31 p.m., Respondent removed one Hydromorphone 2 mg syringe from the Pyxis machine. However, there was no documentation that the medication was administered or wasted.

Patient 5

19. On April 7, 2009, at 11:22 a.m., Respondent removed one Hydromorphone 2 mg syringe from the Pyxis machine. Respondent documented that 1 mg of Hydromorphone was administered. However, there was no documentation that the remaining 1 mg was administered or wasted.

Patient 6

20. On April 7, 2009, at 1:09 p.m., Respondent removed one Hydromorphone 2 mg syringe from the Pyxis machine. Respondent documented that he administered 1 mg, but there was no documentation that the remaining 1 mg of Hydromorphone was administered or wasted.

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Patient 7

21. On April 8, 2009, at 2:33 p.m., Respondent removed one Hydromorphone 2 mg syringe from the Pyxis machine. Respondent documented that he administered 1 mg, but there was no documentation that the remaining 1 mg of Hydromorphone was administered or wasted.

Patient 8

22. On April 9, 2009, at 10:37 a.m. and at 1:44 p.m., Respondent removed one Hydromorphone 2 mg syringe from the Pyxis machine. With regard to the first 2 mg syringe (10:37 a.m.), Respondent documented that he administered 1 mg of Hydromorphone at 10:52 p.m., but there was no documentation that the remaining 1 mg of Hydromorphone was administered or wasted. With regard to the second 2 mg syringe (1:44 p.m.) there is no documentation that any of the Hydromorphone was administered or wasted.

Patient 9

23. On April 13, 2009, Respondent removed a total of 4 mgs of Hydromorphone from the Pyxis machine. Respondent documented that he administered 2 mgs of Hydromorphone to the patient, but there was no documentation that the remaining 2 mgs of Hydromorphone were administered or wasted.

Patient 10

24. On April 16, 2009, at both 3:21 p.m. and 4:24 p.m., Respondent removed one Hydromorphone 2 mg syringe from the Pyxis machine, for a total of 4 mgs. Respondent documented that he administered 1 mg of Hydromorphone at 3:21 p.m. and 1 mg of Hydromorphone at 4:26 p.m., but there was no documentation that the remaining 2 mgs of Hydromorphone were administered or wasted.

Patient 11

25. On April 16, 2009, at 6:51 p.m., Respondent removed one Hydromorphone 2 mg syringe from the Pyxis machine. There was no physician order for the medication to be given to this patient. Further, there was no documentation that the 2 mgs of Hydromorphone were administered or wasted.

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Patient 12

26. On April 17, 2009, at 7:35 p.m., Respondent removed one Hydromorphone 2 mg syringe from the Pyxis machine. There was no physician order for the medication to be given to this patient. Further, there was no documentation that the 2 mgs of Hydromorphone were administered or wasted.

SECOND CAUSE FOR DISCIPLINE
(Unprofessional Conduct - Illegally Possessing Controlled Substances)
(Bus. & Prof. Code §§ 2761(a) & 2762(a))

27. Respondent has subjected his Registered Nurse License to discipline for unprofessional conduct under Code section 2761, subdivision (a) (unprofessional conduct) and Code section 2762, subdivision (a) (obtain or possess in violation of law any controlled substance or any dangerous drug), in that Respondent withdrew narcotics, often without a physician's order, and failed to properly document the use or waste of these medications while working as a Nurse at MPHS. The circumstances are as follows:

28. Complainant re-alleges the allegations contained in paragraphs 13 through 26 above, and incorporates them by reference as if fully set forth.

29. As a result of the review of Respondent's Pyxis machine activity from April 1, 2009 through June 10, 2009, Respondent was placed on administrative leave. An investigative meeting was held on June 11, 2009 with Respondent and his CNA representative. At the meeting, Respondent attributed the lack of documentation and waste to "sloppy practices." At the request of the CNA representative, another month (March 2009) was audited. The audit revealed additional discrepancies.[2] On June 15, 2009, MPHS terminated Respondent's employment.

30. Respondent's handling of medication and failure to properly account for and document all medications as either administered or wasted is not consistent with the standard policies and procedures at MPHS. Further, Respondent removed medications from the Pyxis machine without a physician's order. (See paragraphs 15, 25, and 26, above). Respondent was illegally in possession of controlled substances when he removed medications without a

[2] For example, on March 4, 2009, Respondent removed a 10 mg vial of Morphine and administered a 6 mg dose but did not record the waste of the remaining 4 mgs.

physician's order. Respondent's failure to properly account for the administration or waste of controlled substances is contrary to Nursing policies, procedures, and regulations.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters alleged in this Accusation, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 683001, issued to David Paul Alexander;

2. Ordering David Paul Alexander to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 2/7/11

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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